

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.

VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

09465

**CERTIFICATE OF DEATH**

Reg. Dist. No.....

9470

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town)	St. Mary's MARYLAND	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY TOWN Rural Mechanicsville St. Mary's
TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	Length of Stay (in this place)	STREET ADDRESS	(If rural give location)
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE</b> (Month) (Day) (Year) <b>OF DEATH</b> Aug. 11, 1958	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED Never married	8. DATE OF BIRTH June 27, 1925
9. AGE last birthday 33 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME James Edward Holton	14. MOTHER'S MAIDEN NAME Mary Agnes Wills	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) No	16. SOCIAL SECURITY NO.
17. INFORMANT & ADDRESS Mrs Mary A. Holton Mechanicsville,		18. MEDICAL CERTIFICATION Maryland	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 199.2 IMMEDIATE CAUSE (A) <i>Carcinomatosis</i>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9 Aug., 1958, to 11 Aug., 1958, that I last saw the deceased alive on 9 Aug., 1958, and that death occurred at M., from the causes and on the date stated above. SIGNATURE <i>Howard L. Morrison</i> ADDRESS (Street, city, town, state) <i>Mechanicsville</i> DATE SIGNED <i>8-13-18</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 8/14/58	NAME OF CEMETERY OR CREMATORIAL St. Joseph's	LOCATION (City, town, or county) Morganza, Maryland
24. REC'D BY REGISTRAR AUG 18 '58	REGISTRAR'S SIGNATURE <i>Orlina S. Traas</i>	25. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.	
DATE	ADDRESS		

## CERTIFICATE OF DEATH

Date of Birth

Place of Birth

Name of Hospital or Clinic

Address of Hospital or Clinic

Name of Physician

Address of Physician

Name of Hospital or Clinic

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**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10W

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18****CERTIFICATE OF DEATH**

09466

Reg. Dist. No.....

9471

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	St. Mary's Valley Lee	MARYLAND LENGTH OF STAY (In this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Valley Lee
HOSPITAL OR INSTITUTION OR STREET ADDRESS	20yrs.		
<b>3. NAME OF DECEASED</b> (Type or Print)		(First) Henry A	(Middle) (Last) Biscoe
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 14, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 72 yrs.
13. FATHER'S NAME Major Gladden		11. BIRTHPLACE (State or foreign country) Drayden, Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
17. INFORMANT & ADDRESS Laura V. Biscoe Valley Lee, Md.		14. MOTHER'S MAIDEN NAME Mary Biscoe	
<b>18. MEDICAL CERTIFICATION</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.0 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		Cerebral Occlusion Arterio sclerotic Heart Disease	
		INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs 10-20 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.</b>			
SIGNATURE <i>Ernest D. Rehm</i>		M.D. ADDRESS (Street, city, town, state) <i>Ley. St. 211 &amp; 18ay 87</i> DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 8/20/15	NAME OF CEMETERY OR CREMATORIAL Bethesda	LOCATION (City, town, or county) (State) Valley Lee, Md.
24. REC'D BY REGISTRAR DATE AUG 19 '58	REGISTRAR'S SIGNATURE <i>C. L. Haas</i>		
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. Clarke Mattingley Leonardtown, Md.			

BY PROMISING IT IS TO THE STATE OF TEXAS

# CERTIFICATE OF DEATH

DECEASED PERSON

NAME OF DECEASED PERSON

NAME OF DOCTOR

ADDRESS OF DECEASED PERSON

ADDRESS OF DOCTOR

NAME OF DECEASED PERSON

NAME OF DOCTOR

DECEASED

DECEASED

DECEASED

DECEASED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

09467

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>		c. LENGTH OF STAY IN lb RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST MARYS HOSPITAL</b>		e. STREET ADDRESS <b>X VALLEY LEE</b>	
3. NAME OF DECEASED (Type or print) <b>Infant girl</b>		First <b>Briscoe</b>	Middle <b>Ethel</b>
4. DATE OF DEATH <b>AUGUST 17 1958</b>		Month <b>AUGUST</b>	Day <b>17</b>
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>AUG. 16 1958</b>		9. AGE (in years from birthday) yrs. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MD,</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis J. Dailey</b>		14. MOTHER'S MAIDEN NAME <b>MARY Ethel Briscoe</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>76.15</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Premature birth (6 months)</b> (b) DUE TO <b>Descent prævia</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>Aug 16 1958</b>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 16, 1958</b> to <b>Aug 17, 1958</b> , that I last saw the deceased alive on <b>Aug 16, 1958</b> , and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Great Mills, Md</b>		DATE SIGNED <b>Aug 17/58</b>	
ACTUAL SIGNATURE <b>P.J. Bean MD</b>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 16 1958</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>St Alloysius</b>		22d. LOCATION (City, town, or county) (State) <b>Leonardtown Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McClure Hallingay Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 19 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Anna S. Lewis</b>	



1

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Item 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

VS. ATSM  
SM 2/57

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 9473 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 4 Film G233 8-27-58 et

09468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Georgia b. COUNTY Houston	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Patuxent River,		c. LENGTH OF STAY IN 1b 10 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marine Barracks		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Johnny Edward CARAWAY		First Middle	4. DATE OF DEATH Month Day Year August 9, 1958
5. SEX Male	6. COLOR OR RACE Chucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1940
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Private		10b. KIND OF BUSINESS OR INDUSTRY U.S. Marine Corps	9. AGE (In years from birthday) 18 yrs.
13. FATHER'S NAME Mandil CARAWAY		11. BIRTHPLACE (State or foreign country) Georgia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 5/57 to 8/58		16. SOCIAL SECURITY NO. 253-58-6046	17. INFORMANT Official U.S. Navy Records, USNAS, Patuxent River, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 919.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH Immediately	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Accidentally shot while two shipmates were playing with rifle.	
20c. TIME OF INJURY Month, Day, Year 7:25 AM Aug 9 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Marine Bks. 20f. (City or town) USNAS, (County) (State) Patuxent River, St. Mary's, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W.L.CAMPBELL, LT MC USNR, USNAS, Patuxent River, Maryland		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WM. D. BOYD, M.D. <i>John W. Boyd</i>		12 August 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/15/58	22c. NAME OF CEMETERY OR CREMATORIUM Warner Robbins
23. FUNERAL DIRECTOR'S SIGNATURE W.C. Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR AUG 14 '58	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Traas</i>	



## INSTRUCTIONS

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**To FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9474

## CERTIFICATE OF DEATH

09469

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>St. Mary's</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>TOWN Leonardtown</b>		MARYLAND LENGTH OF STAY (in this place) <b>8hrs.</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>St. Mary's Hospital</b>		STATE <b>Maryland</b> COUNTY <b>St. Mary's</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWN Lexington Park</b> STREET ADDRESS <b>28 Lei Drive</b>	
3. NAME OF DECEASED (Type or Print) <b>Mark John Daggett</b>		4. DATE (Month) (Day) (Year) <b>Aug. 17, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>April 28, 1958</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carol Daggett</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Mary Ferrari</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT & ADDRESS <b>Mrs Carol Daggett 28 Lei Drive</b>		18. MEDICAL CERTIFICATION Lexington Park, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>754.5 IMMEDIATE CAUSE (A) Heart Failure</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		<b>Single Ventricle with Pulmonary Stenosis 3 1/2 mg.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>May 1, 1958</b> , to <b>Aug. 17, 1958</b> , that I last saw the deceased alive on <b>Aug. 17, 1958</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>W.H. Patrich</b> M.D. DATE SIGNED <b>Lexington Park Md. 861858</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>8/20/58</b>	
24. REC'D BY REGISTRAR DATE <b>AUG 19 '58</b>		REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	
25. FUNERAL DIRECTOR'S SIGNATURE		LOCATION (City, town, or county) <b>Pittsburg, California</b>	
		ADDRESS	

2078371XV4

ST. LOUIS CITY-HEALTH DEPARTMENT STATE CHAIRMEN

CERTIFICATE OF  
STATE TO STATE

RECORDED IN OFFICE OF CLERK OF COURT

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10549

9475

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RFD Mechanicsville</b>		c. LENGTH OF STAY IN 1b <b>Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		e. STREET ADDRESS <b>1734 Corcoran St. N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Mary Hortense Davis</b>		4. DATE OF DEATH <b>August 26</b>	Month Year Doy
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/ 4/ 1913</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9. AGE (In years last birthday) <b>45</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>James Butler</b>		14. MOTHER'S MAIDEN NAME <b>Cecelia Stevens</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. -----	17. INFORMANT <b>Cecelia Butler - RFD Mechanicsville, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o.) <b>153.9</b> DUE TO Cancer Intestinal		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (o.), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m.      p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 1<sup>st</sup>, 1958</b> , to <b>Aug 26, 1958</b> , that I last saw the deceased alive on <b>August 20, 1958</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles Greenwell</b>		ADDRESS (Street, city or town, state) <b>Leonardtown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/29/58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>ST. Johns Cemetery</b>
22d. LOCATION (City, town, or county) <b>Hollywood, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 15 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon covers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HEALTH - STATE OF HAWAII  
CERTIFICATE OF DEATH

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09471

## CERTIFICATE OF DEATH

Reg. Dist. No.

9477

1. PLACE OF DEATH o. COUNTY <i>St. Marys</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Md.</i>		b. COUNTY <i>St. Marys</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>		c. LENGTH OF STAY IN 1b <i>Leonardtown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Valley Lee</i>		d. STREET ADDRESS <i>Valley Lee</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St. Marys</i>				d. STREET ADDRESS <i>Valley Lee</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <i>Mary</i>	Middle <i>Charlotte</i>	Last <i>Mason</i>	4. DATE OF DEATH <i>Aug. 2 1958</i>	Month <i>Aug.</i>	Day <i>2</i>	Year <i>1958</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-2-58</i>	9. AGE (In years lost birthday) yrs. <i>35</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>Mason James</i>		14. MOTHER'S MAIDEN NAME <i>Clayton, Betty</i>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Records</i>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>761.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>Perimortem birth (6 months)</i>						INTERVAL BETWEEN ONSET AND DEATH					
(b) DUE TO <i>Placenta previa</i>											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Great Mills, Md</i>		20f. (City or town) <i>Great Mills, Md</i>		(County) <i>Calvert Co</i>		(State) <i>Md</i>	
21. I certify that I attended the deceased from <i>Aug. 2, 1958</i> , to <i>Aug. 2, 1958</i> , that I last saw the deceased alive on <i>Aug. 2, 1958</i> , and that death occurred at <i>3:35 AM</i> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>Great Mills, Md</i>					DATE SIGNED <i>8/2/58</i>
ACTUAL SIGNATURE <i>P.J. Bean MD</i>											
PHYSICIAN'S NAME (Type) <i>P.J. Bean MD</i>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/3/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>St. George's</i>		22d. LOCATION (City, town, or county) <i>Valley Lee, Md</i>		(State) <i>Md</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>McCullough Leonardtown, Md</i>		ADDRESS <i>Leonardtown, Md</i>		24a. REC'D BY REGISTRAR DATE <i>AUG 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Alv. Leach</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached or use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9476

## CERTIFICATE OF DEATH

Reg. Dist. No.

09470

1. PLACE OF DEATH a. COUNTY <i>St. Marys</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leonardtown</i>		c. LENGTH OF STAY IN 1b d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>Valley Lee</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>ST. MARY'S</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Robin Charlene Mason</i>		First <i>Robin</i>	Middle <i>Charlene</i>		
4. DATE OF DEATH <i>August 2 1958</i>	Month <i>August</i>	Day <i>2</i>	Year <i>1958</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-2-58</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>—</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Mason, James</i>	14. MOTHER'S MAIDEN NAME <i>Clayton Betty</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Hospital Records</i>	Address <i>—</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>761.5</i> DUE TO <i>Premature birth (Cervical)</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Placenta previa</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.      While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <i>Aug 2 1958</i> , to <i>Aug 3 1958</i> , that I last saw the deceased alive on <i>Aug 2 1958</i> , and that death occurred at <i>3:30 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Great Mills, Md</i>	DATE SIGNED <i>Aug 4 1958</i>
ACTUAL SIGNATURE <i>P.J. Bean M.D.</i>		PHYSICIAN'S NAME (Type) <i>P.J. Bean M.D.</i>		22d. LOCATION (City, town or county) <i>Valley Lee, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8/3/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St George's</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>McHattinley Leonardtown MD</i>		ADDRESS <i>22782 38 XVO</i>		24a. REC'D BY REGISTRAR DATE AUG 5 '58	
				24b. REGISTRAR'S SIGNATURE <i>All research</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached or use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**To FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

The bottom copy may be retained by the hospital or attending physician.

V5 A15C-55 10/M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

9478

09472

**CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>			<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>		
COUNTY <b>St. Mary's</b> Maryland			STATE <b>Maryland</b> COUNTY <b>St. Mary's</b>		
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Ridge</b>		
TOWN <b>Leonardtown</b>		<b>6 days</b>	STREET ADDRESS <b>Ridge</b>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>St. Mary's Hospital</b>					
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Susan Jean Raley</b>			<b>4. DATE OF DEATH</b> <b>Aug. 27, 1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Jan. 13, 1873</b>	9. AGE last birthday <b>85</b>	IF UNDER 1 YEAR yrs. <b>7</b> Months <b>14</b> Deys Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>George W. Gatton</b>			14. MOTHER'S MAIDEN NAME <b>Martha Norris</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>Mrs Lillian Taylor Ridge, Maryland</b>	
<b>18. MEDICAL CERTIFICATION</b>					
<b>I</b> DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE <b>Gangrenous arteriosclerosis</b> ANTECEDENT CAUSE(S) DUE TO <b>Diabetes arteritis with necrosis of digits</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <b>Diabetes mellitus</b> 260.0 (C)					
INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b> <b>3 months</b>					
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
? ?					
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) <b>Great Mills</b> (State) <b>Md.</b>	
21d. TIME OF INJURY (Month) <b>Aug.</b> (Day) <b>26</b> (Year) <b>1958</b> (Hour) <b>M.</b>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<b>22. I hereby certify that I attended the deceased from <b>June 11, 1958</b> to <b>Aug. 27, 1958</b>, that I last saw the deceased alive on <b>Aug. 26, 1958</b>, and that death occurred at <b>4A.M.</b> from the causes and on the date stated above.</b>					
SIGNATURE <b>P. J. S. M. H.</b> ADDRESS (Street, city, town, state) <b>Great Mills Rd.</b> DATE SIGNED <b>8/28/58</b>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>8/30/58</b>	NAME OF CEMETERY OR CREMATORIUM <b>St. Michael's</b>		LOCATION (City, town, or county) <b>Ridge,</b> (State) <b>Maryland</b>
24. REC'D BY REGISTRAR DATE <b>SEP 3 '58</b>		REGISTRAR'S SIGNATURE <b>John S. Kraus</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>W. Clarke Mattingley Leonardtown, Md.</b>		

ST. GEORGE'S ISLAND TO TRENTHAM STATE CHANNEL

CERTIFICATE OF DATA

DATA SHEET

DATA SHEET NUMBER 2

DATE 1904

TIME 11:00

DATA SHEET NUMBER 3

DATE 1904

TIME 11:00

STATION 5000

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC L-55 10W

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

Items 1.9 FilmG233 8-27-58 et

09473

**CERTIFICATE OF DEATH**

9479

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY St. Mary's MARYLAND		STATE Maryland COUNTY St. Mary's	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN St. Mary's City		LENGTH OF STAY (in this place) 7 days	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		X STREET ADDRESS (If rural give location)	
institution. Death did not occur in an /			
<b>3. NAME OF DECEASED (Type or Print)</b>		<b>4. DATE OF DEATH</b>	
(First) Joseph (Middle) Solomon (Last) Russell		Aug. 3, 1958	
S. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Aug. 6, 1876
9. AGE last birthday 80 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if part-time) Merchant	11. KIND OF BUSINESS OR INDUSTRY Store	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Frank Russell	14. MOTHER'S MAIDEN NAME Mary Emmeline Cullison	17. INFORMANT & ADDRESS Joseph S. Russell Jr., Maddox, Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. None	18. MEDICAL CERTIFICATION <i>Congestive failure Arteriosclerotic heart dis.</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21g. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from May 1958, to July 1958, that I last saw the deceased alive on 27/5/58, 1958, and that death occurred at 10A.M. from the causes and on the date stated above. SIGNATURE <i>Leon W. Bentz</i> M.D. ADDRESS (Street, city, town, state) DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 8/5/58	
24. REC'D BY REGISTRAR DATE AUG 5 '58		NAME OF CEMETERY OR CREMATORIAL Christ Episcopal	
REGISTRAR'S SIGNATURE <i>Albert E. Deuch</i>		LOCATION (City, town, or county) (State) Chaptico, Maryland	
25. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		ADDRESS Leonardtown, Md.	

DEPARTMENT OF STATE - DIVISION OF RECORDS

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE AT DEATH	CAUSE OF DEATH
WILLIAM HENRY COOPER	65	CHRONIC DISEASE AGE RELATED
ADDRESS	STREET	CITY
100 W. 12TH ST.	APT. 202	NEW YORK CITY
NAME OF DOCTOR	NAME OF HOSPITAL	NAME OF FUNERAL HOME
DR. JAMES MCGOWAN	HOSPITAL FOR SICK CHILDREN	WILLIAMS & CO.
RELATIONSHIP TO DECEASED	TIME OF DEATH	TIME OF BURIAL
WIFE	10:00 PM	11:00 PM
TIME OF DEATH	TIME OF BURIAL	TIME OF INTERMENT
10:00 PM	11:00 PM	11:00 PM
NAME OF CLERK	DATE	TIME
JOHN H. COOPER	APRIL 19, 1958	11:00 PM

**FOR STATE  
HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
a MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9489

Item 8 Film G233 9-18-58 et

09474

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Lexington Park			d. STREET ADDRESS Rural		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOSEPH ARTHUR THOMPSON		First Middle Last	4. DATE OF DEATH	Month Day Year	
5. SEX Male Colored WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. COLOR OR RACE NEVER MARRIED <input type="checkbox"/>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1917	9. AGE (In years last birthday) 41 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Charles A. Thompson			14. MOTHER'S MAIDEN NAME Sarah Holmes Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No			16. SOCIAL SECURITY NO. -----		
17. INFORMANT			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491 X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/4/58	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/7/58		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS St. Francis Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				22d. LOCATION (City, town, or county) Compton, Md.	
				24a. REC'D. BY REGISTRAR AUG 18 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thompson	

STATE  
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1960

Благодарю

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09475

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit Permit. File Pages 1, 2 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

V.S. A15ME  
SM 2/57

9481

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b>		b. COUNTY <b>Arlington</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Valley Lee</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b>		d. STREET ADDRESS <b>2312 - Ives Street</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Nellie Collard Towers</b>		First	Middle	Last	4. DATE OF DEATH <b>August 7 1958</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Jan. 5, 1870</b>	9. AGE (In years last birthday) <b>88 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>George Talbert</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>Mrs. Florence Mothersead- Arlington, Va.</b>		Address <b>2312 S. Ives St. Arlington, Va.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> INTERVAL BETWEEN ONSET AND DEATH <b>unmed</b> Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) -----	(County) -----	(State) -----	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>  <b>Wm. D. Boyd</b>								
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) <b>William D. Boyd, MD</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/7/58</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/11/58</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Glenwood Cemetery</b>		22d. LOCATION (City, town, or county) <b>Washington, D.C.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>S.H. Hines, Co.</b>		23. PRESENT ADDRESS <b>2901- 14 th St. N.W.</b>		24a. REG'D BY REGISTRAR <b>JUL 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Traas</b>		

**DEBIEGAR EXAMINER'S CERTIFICATE OF DEATH**